Severe mental illness and the GP
Quality and Outcomes Framework

TONY KENDRICK

Tony Kendrick outlines the rationale for the inclusion of performance targets and indicators for the care of people with severe mental illness in the Quality and Outcomes Framework, and discusses the impact this has had on unplanned hospital admissions for both mental and physical health problems.

Severe mental illness (SMI) includes schizophrenia, bipolar disorder and other psychoses.

GENDER DIFFERENCES IN SEVERE MENTAL ILLNESS
The incidence of schizophrenia is higher in men, and the age of onset earlier. Women have higher remission and lower relapse rates, so chronic schizophrenia is more of a problem among men. Social functioning is generally better in women with schizophrenia, and men more often have negative symptoms including social withdrawal and apathy, and so are less likely to seek help for their mental and physical health problems. Substance abuse is also more common in men than women with schizophrenia, which adds to the risk of physical as well as mental health problems.

Men and women experience similar rates of bipolar disorder, but early-onset disorder is commoner in men and again is associated with more severe symptoms, comorbid substance abuse and poorer outcomes.

PHYSICAL HEALTH PROBLEMS IN SMI
Mortality rates for people with SMI are two to three times higher than the general population, and while that is partly due to the risk of suicide, two-thirds of the excess mortality is a result of physical disorders, especially smoking- and obesity-related cardiovascular and respiratory diseases. Compared with the general population, people with SMI have double the risk of diabetes, two to three times the risk of hypertension, three times the risk of dying from coronary heart disease, and ten times the risk of dying from respiratory disease.

RESPONSIBILITY FOR THE CARE OF PEOPLE WITH SMI
In the UK, responsibility for health promotion and care of the physical health of people with SMI sits in primary care with GPs and practice nurses, and GPs help look after patients’ mental health care needs too. Recent research shows one in two people with schizophrenia and one in three people with bipolar disorder are seen regularly only in primary care, with little or no contact with secondary care services.

Nationally, the quality of primary care for people with SMI is assessed by the Quality and Outcomes Framework (QOF). Introduced in 2004, the QOF provides

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Tony Kendrick, MD, FRCGP, FRCPsych, Professor of Primary Care, University of Southampton
financial rewards to general practices for achieving specific quality targets for patients with a range of chronic illnesses. The SMI quality indicators in the QOF cover both mental health care such as monitoring lithium levels for people with bipolar disorder, and physical care, including cardiovascular screening, which is crucially important in the care of people with SMI.

RATIONALE FOR THE QOF SMI INDICATORS
Before the QOF targets were introduced, GPs tended to see people with SMI only if and when they turned up at the practice, treating physical problems only if they were actively presented, and mostly just issuing sickness certificates and repeat prescriptions. Reviews of mental state and psychotropic medication by GPs were very uncommon, and health promotion was almost non-existent. GPs generally run open-ended unstructured clinics, and use an open consultation style, which allows the patient to set the agenda, but this approach (which for most people can be seen as patient-centred) tends to miss problems in patients with the negative symptoms of psychosis, including apathy and withdrawal, and a tendency to neglect problems rather than actively seek help.

To introduce more structure into the care of people with SMI in general practice, we carried out a trial of teaching GPs to set up registers of their long-term mentally ill patients, and carry out structured assessments of their mental and physical health and treatment, every 6 months. This demonstrated improvement in the process of care; changes in drug treatments and referrals to community psychiatric teams were significantly more frequent in the intervention group.

Nazareth and colleagues also carried out a trial of monitoring people with psychosis in general practice in special clinic sessions run jointly by GPs and practice nurses, and found significant improvements in the intervention group in terms of mental health outcomes measured with the Global Assessment Scale and Present State Examination at follow-up.

These studies provided the rationale for the inclusion of performance targets and indicators for the care of people with SMI in the QOF from its inception in 2004. The SMI indicators are shown in Box 1, and the recommended content of SMI reviews is listed in Box 2.

EFFECTS OF THE QOF ON THE CARE OF PEOPLE WITH SMI
Osborn and colleagues looked at the computerised medical records of 18,696 people with SMI and 95,512 people without SMI in the Health Improvement Network general practice database, to compare their care before and after the introduction of the QOF, in particular rates of measurement of blood pressure (BP), glucose, cholesterol and body mass index (BMI). Prior to 2004, people with SMI aged less than 60 were significantly less likely to receive each measurement compared to people without SMI. The relative rates were around two-thirds for BMI, BP and glucose, and half for cholesterol. By 2007, people less than 60 years of age with SMI were equally likely to receive a measurement of BMI, glucose and cholesterol, and the relative shortfall in screening for BP had narrowed to 87%. However, people with SMI over 60 years of age remained significantly less likely to be screened.

We hypothesised that the proactive, more structured and therefore better quality care incentivised by the QOF might lead to fewer unplanned hospital admissions for both mental and physical health problems, through preventing emergency situations arising. We further suggested that more planned hospital admissions for physical health problems might result, through identifying and tackling undetected and unmet needs. However, an analysis led by Rowena Jacobs of hospital admission rates according to QOF achievement levels by practices showed that, contrary to expectation, higher QOF achievement was positively related to emergency admissions for both mental and physical health problems, as well as to elective physical health admissions.

Possible explanations for our findings are that a higher quality of primary care as measured by the QOF may not effectively prevent the need for secondary care, although it may have been that patients received their QOF checks post-discharge, rather than prior to admission. Alternatively, people with more severe SMI at greater risk of admission may be more likely to be registered with practices that are better organised to provide their care and that better QOF performance, and the better quality primary care they receive may be being picked up unmet needs for secondary care, which lead on to admissions appropriately. Patient level data on the quality of care in general practice are required to unpick the causes of the positive association between QOF achievement levels and hospital admissions in further research, which we aim to pursue.

CHANGES TO THE SMI QOF INDICATORS IN 2014/15
From April 2014, there was a 38% reduction in the QOF, with 341 points of just less than 1000 in total being removed. This includes the removal of the requirement to carry out an annual check of BMI, cholesterol and glucose for people...
with SMI. It will be important to monitor whether the improved cardiovascular screening shown by Osborn and colleagues persists following its removal. General practice registers of people with SMI and annual reviews of patients’ care plans are still incentivised in the QOF, so obesity, lipid and diabetes checks could persist if they are carried out during those checks, but that will be up to the individual GP to decide.

In the meantime, NHS England, which oversees the commissioning of health care, has signalled that it would like to see funding that was previously in the QOF to be targeted specifically towards reducing admissions, partly through having a named doctor responsible for people with long-term conditions, which would include people with SMI, to provide greater continuity of care. This development will also need to be evaluated to determine whether a higher standard of care is actually delivered as a result, to this most vulnerable group of patients.

Declaration of interests: none declared.

REFERENCES